Reference Guide For Active Employees

Hawaii Employer-Union Health Benefits Trust Fund

Effective July 1, 2004

Reference Guide for Active Employees

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INTRODUCTION

This benefits booklet is designed to help public employees understand the benefit options available to them and assist public employees in enrolling or changing their enrollment in the benefit plans offered by the Hawaii Employer-Union Health Benefits Trust Fund (EUTF). This booklet will also be available at the EUTF's website, www.eutf.hawaii.gov, where you can easily access it when you have questions about your benefits.

2004 OPEN ENROLLMENT IS EASY!

The open enrollment period is April 1 through April 30, 2004. Each active employee is receiving this booklet along with a pre-completed Open Enrollment Form for Active Employees (OE-1) that contains the information that EUTF had available as of the beginning of March 2004. Each employee is asked to review the information for accuracy of information and make any changes that are needed. You may cross out any information that should be deleted and print legibly any new information.

If you have no changes, you are done with open enrollment. You will be re-enrolled in the same plans and coverage that you currently have. Otherwise, return the changed and signed OE-1 by April 30, 2004.

Rates

At the time this reference guide went to press, collective bargaining was not complete. When collective bargaining is complete you will be informed of the employee contribution required for each plan.

New Plan Options

The EUTF has added benefit options this year: **two Dual-Coverage Medical Plans** for Active Employees who have medical coverage through private sector or federal government plans may select a dual-coverage medical plan as a supplement. Active employees have a choice between dual-coverage benefits offered by HMSA and the Royal State National Insurance Company Limited. In addition, Active Employees have the option to choose a **Prescription Drug-Only Plan**. This is offered by HMSA and has the same benefits as the Prescription Drug Plan bundled with the PPO plan. Please note that there is no medical-only plan option.

These new dual-coverage options are described beginning on page 20 and the prescription drug-only is described on page 15.

OPEN ENROLLMENT ASSISTANCE

The EUTF invites you to attend Open Enrollment informational sessions. The sessions shown on the following page are confirmed as of the time this booklet went to press. Please check with our website, www.eutf.hawaii.gov, for the most current schedule.

These meetings are offered so that you can meet with your insurance carriers to learn more about your EUTF benefit plans. The meetings will begin with a half-hour overview of the benefits. The remaining hour and a half is for you to meet with the insurance carriers and the EUTF staff. If you have received your pre-completed open enrollment form (OE-1) from the EUTF, please bring it with you.

Please note: Because there are minimal changes to the plans in 2004, the EUTF has not requested paid time off for employees to attend these meetings.

Addresses for the informational sessions are shown below.

OAHU
Leeward Community College
96-045 Ala Ike
Pearl City, HI 96782

State Capitol Auditorium
415 South Beretania Street
Honolulu, HI 96813

UH Kuykendall Auditorium
1733 Donagho Road
Honolulu, HI 96822

Windward Community College
45-720 Keaahala Road
Kaneohe, HI 96744

Kapolei Hale Conference Room
1000 Uluohia Street
Kapolei, HI 96707

HAWAII
Aunt Sally Kalehano's Lu'au Hale
799 Piilani Street
Hilo, HI 96720

Kekuaokalani Gym
75-5530 Kuakini Highway
Kailua-Kona, HI 96743

Waimea State Office Bldg Conference Room
67-5189 Kamamalu Street
Kamuela, HI 96743

2004 OPEN ENROLLMENT MEETING SCHEDULE

Locations continued:

MAUI

War Memorial Gym 700 Halia Nakoa St, Unit 2 Wailuku, HI 96793	**Wailuku Community Center** 395 Waena Place Wailuku, HI 96793	**Maui Community College** 310 Kaahumanu Kahului, HI 96732

KAUAI

	War Memorial Convention Center 4191 Hardy Lihue, HI 96766	

OAHU

Date	Start Time	Location
April 6	12:00 PM	UH - Kuykendall Auditorium
April 6	2:00 PM	UH - Kuykendall Auditorium
April 7	7:00 AM	Kapolei Hale Conference Room A/B
April 7	11:00 AM	Kapolei Hale Conference Room A/B
April 7	4:00 PM	Kapolei Hale Conference Room A/B
April 12	7:30 AM	State Capitol Auditorium
April 12	11:00 AM	State Capitol Auditorium
April 12	2:30 PM	State Capitol Auditorium
April 13	7:00 AM	Kapolei Hale Conference Room A/B
April 13	11:00 AM	Kapolei Hale Conference Room A/B
April 13	4:00 PM	Kapolei Hale Conference Room A/B
April 14	7:30 AM	State Capitol Auditorium
April 14	11:00 AM	State Capitol Auditorium
April 14	2:30 PM	State Capitol Auditorium
April 15	8:00 AM	UH - Kuykendall Auditorium
April 15	10:00 AM	UH - Kuykendall Auditorium
April 16	1:00 PM	Leeward Community College GT 105
April 16	3:00 PM	Leeward Community College GT 105
April 20	11:00 AM	Leeward Community College GT 105
April 20	1:00 PM	Leeward Community College GT 105
April 21	8:00 AM	Akoakoa Rm 105, Windward Community College
April 21	11:00 AM	Akoakoa Rm 105, Windward Community College
April 21	1:00 PM	Akoakoa Rm 105, Windward Community College
April 29	7:00 AM	Kapolei Hale Conference Room A/B
April 29	11:00 AM	Kapolei Hale Conference Room A/B
April 29	4:00 PM	Kapolei Hale Conference Room A/B

2004 OPEN ENROLLMENT MEETING SCHEDULE continued

HAWAII

Date	Start Time	Location
April 6	8:30 AM	Aunty Sally Kaleohano's Lu'au Hale
April 6	11:00 AM	Aunty Sally Kaleohano's Lu'au Hale
April 6	2:30 PM	Aunty Sally Kaleohano's Lu'au Hale
April 8	9:00 AM	Kekuaokalani Gym
April 8	11:00 AM	Kekuaokalani Gym
April 8	2:00 PM	Kekuaokalani Gym
April 22	8:30 AM	Aunty Sally Kaleohano's Lu'au Hale
April 22	11:00 AM	Aunty Sally Kaleohano's Lu'au Hale
April 22	2:30 PM	Aunty Sally Kaleohano's Lu'au Hale
April 26	9:00 AM	Waimea Office Building Conference Room
April 26	11:00 AM	Waimea Office Building Conference Room
April 26	2:30 PM	Waimea Office Building Conference Room

MAUI

Date	Start Time	Location
April 2	8:30 AM	Kalama Rm 103, Maui Community College
April 2	11:00 AM	Kalama Rm 103, Maui Community College
April 2	2:30 PM	Kalama Rm 103, Maui Community College
April 13	8:30 AM	War Memorial Gym
April 13	11:00 AM	War Memorial Gym
April 13	2:30 PM	War Memorial Gym
April 14	2:00 PM	Wailuku Community Center
April 14	4:00 PM	Wailuku Community Center

KAUAI

Date	Start Time	Location
April 5	8:30 AM	War Memorial Convention Center
April 5	11:00 AM	War Memorial Convention Center
April 5	2:30 PM	War Memorial Convention Center
April 19	8:30 AM	War Memorial Convention Center
April 19	11:00 AM	War Memorial Convention Center
April 19	2:30 PM	War Memorial Convention Center

Employee-Beneficiary Responsibilities

Employee-beneficiaries are responsible for:

- Providing current and accurate personal information as prescribed in this booklet
- Paying the employee's premium contributions in the amount or amounts provided by statute, an applicable bargaining unit agreement, or by the applicable Fund benefit plan;
- Paying the employee's premium contributions at the times and in the manner designated by the board; and
- Complying with the Fund's rules.

Any public employer whose current or former employees participate in Fund benefit plans is responsible for:

- Providing information as requested by the Fund under section 87A-24(9) of the Hawaii Revised Statutes;
- Paying the employer's premium contributions in the amount or amounts provided by statute or an applicable bargaining unit agreement and at the times and in the manner designated by the board;
- Assisting the Fund in distributing information to and collecting information from the employee-beneficiaries; and
- Complying with the Fund's rules.

Enforcement Actions of the Fund

Verifications

The EUTF may require periodic verification of eligibility for employee-beneficiaries and dependent-beneficiaries enrolled by an employee-beneficiary in EUTF benefit plans. The board may set standards and procedures for the required verification. If verification is not provided in accordance with the standards and procedures established by the board, the dependent-beneficiary's enrollment shall be cancelled as set forth in the Administrative Rules. The Administrative Rules are available at the EUTF website, www.eutf.hawaii.gov.

Contribution Shortages

A notice of contribution shortage shall be sent to an employee-beneficiary at his or her last known address if any portion of the employee-beneficiary's required semi-monthly contributions is not paid or is not withheld from the employee-beneficiary's earnings and transmitted to the Fund. The notice shall be sent within fifteen days of the date on which the required semi-monthly contribution payment was due. The notice shall require the employee-beneficiary to make full payment of the contribution shortage prior to the last day of the second pay period immediately following the date that the required semi-monthly contribution payment was due.

Regardless of whether or not the notice of contribution shortage is received by the employee-beneficiary, if the employee-beneficiary fails to make full payment by the last day of the second pay period immediately following the date that the required semi-monthly contribution payment was due, the employee-beneficiary's enrollment in the benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under such enrollment shall be canceled as set forth in Rule 4.12(c).

Cancellation of an employee-beneficiary's coverage pursuant to this rule shall not affect the Fund's right to collect any and all contribution shortages from the employee-beneficiary.

Other Actions

The Fund shall have the right and authority to file actions in any court, including but not limited to the courts of the State of Hawaii and the United States of America, to enforce the foregoing obligations and to collect premium contributions. Nothing in this rule is intended to limit or restrict the rights or remedies otherwise available to the Fund.

Active Employee Eligibility

Eligibility for coverage is determined by the Administrative Rules adopted by the EUTF. Enrollments, terminations, and other changes must be presented through your employer to the EUTF. If you have any questions concerning eligibility provisions, you should check with your personnel office, call the EUTF Customer Service at 808-586-7390 or reference the Administrative Rules posted on the EUTF website, www.eutf.hawaii.gov.

Health Plans

Employee-beneficiaries. The following persons shall be eligible to enroll as employee beneficiaries in the benefit plans offered or sponsored by the Fund:

- An employee, including an elective officer of the State, county or legislature
- A retired employee
- Surviving spouse of an employee killed in performance of duty, spouse does not remarry
- Surviving spouse of a retired employee, spouse does not remarry

- Unmarried child of an employee killed in performance of duty providing child is under age 19 and has no surviving parent
- Unmarried child of retiree and under age 19 with no surviving parent

Please note: Surviving spouse coverage does not extend to domestic partners.

Dependent-beneficiaries. The following persons shall be eligible for coverage as dependent-beneficiaries in the benefit plans offered or sponsored by the Fund:

- Spouse or domestic partner (DP)
- Unmarried children under age 19 or full-time student under the age of 24
- Unmarried child incapable of self-support due to mental/physical incapacity that existed prior to age 19
- Child covered by terms of a qualified medical child support order (QMCSO).

Long-Term Care

The following persons shall be eligible, provided that they meet the age, enrollment, medical underwriting and contribution requirements of such plans:

- Employee-beneficiaries and their spouses, parents, and grandparents;
- Employee-beneficiaries' in-law parents and grandparents; and
- Qualified-beneficiaries who enroll between the ages of twenty and eighty-five.

Group Life Insurance

Employees and retired employees are eligible for any group life insurance plans offered or sponsored by the Fund, provided that they comply with the age, enrollment, underwriting, and contribution requirements of such plans.

Special Eligibility Requirements

Student

A child over age 19 and under 24 is eligible if attending a full-time accredited college, university or technical school. This includes children who are away at school and dependent upon you for support.

Domestic Partner

Person in a spouse-like relationship with an employee-beneficiary who meets the following requirements:

1. Intend to remain in a domestic partnership with each other indefinitely
2. Have a common residence and intend to reside together indefinitely
3. Jointly and severally responsible for each other's basic living expenses incurred in the domestic partnership such as food, shelter and medical care
4. Neither are married or a member of another domestic partnership
5. Not related by blood in a way that would prevent them from being married to each other in the State of Hawaii
6. Both at least 18 years of age and mentally competent to contract
7. Consent to the domestic partnership not been obtained by force, duress or fraud
8. Both sign and file a declaration of domestic partnership (affidavit) to the Fund

If your domestic partner does not qualify as your dependent for tax purposes, the employer's portion of the premium for your domestic partner will be deemed taxable income and reported to you on your W-2. This income is subject to normal payroll taxes. Consult your tax advisor to determine your domestic partner's status. If you determine that your domestic partner is a dependent, submit a completed Affidavit of "Dependency" for Tax Purposes (available on the EUTF website, www.eutf.hawaii.gov) to the Fund.

Enrollment

During Open Enrollment 2004, you need only return your pre-completed OE-1 form if you are making changes. Subsequently, those who become eligible must complete an EUTF Enrollment Form for Active Employees (EC-1).

If you do not enroll all eligible members of your family within 30 days of the time you or they first become eligible for coverage, you must wait until the next Open Enrollment period to do so. Open Enrollment periods generally occur once a year, usually two to three months prior to July 1. Coverage dates for all plans begin July 1 and end June 30 of the following year.

ID Cards

After you initially enroll, you will receive identification cards from the plans as follows:

- HMSA and HDS will issue two identical ID cards showing the name of the subscriber.
- Kaiser issues an ID card for each enrolled member of a family upon initial enrollment.
- VSP, Mutual Benefit Association of Hawaii (provider of ChiroPlan) and Royal State do not issue ID cards.

Dual Enrollment Is Not Allowed

No one may be enrolled as both an employee-beneficiary and a dependent-beneficiary. If you and your spouse are employees covered by the EUTF, you may each enroll for Self Only coverage or one of you may enroll for a Family coverage.

Medicare Part B Reimbursement

Anyone enrolled in an active employee medical plan who is also enrolled in Medicare Part B does not receive reimbursement from the EUTF for their premiums. Only retirees and their spouses, who are enrolled in an EUTF retiree medical plan, are eligible for the Part B reimbursement. Domestic partners of retirees are not eligible for Part B reimbursement.

Change of Coverage

To change your coverage, you should contact your human resource representative and complete an EC-1 form. You are eligible to change your coverage outside the Open Enrollment period under the following circumstances:

1. You marry and want to enroll your spouse and newly eligible dependent children.
2. You need to enroll a newborn or newly adopted child. In order to add a newly adopted child to your coverage, you must provide court documents verifying the adoption in order to have the application accepted.
3. You have a change in family status involving the loss of eligibility of a family member (separation, divorce, death, child marries, no longer lives with you, or turns age 19 or 24 for student).
4. Your spouse's or eligible dependent's employment status changes resulting in a loss of health coverage.
5. You move out of your plan's service area.

Effective Dates of Coverage

For new hires, the effective date of coverage is the first day of work. There is no waiting period following your date of hire before your health benefits coverage begins, provided you submit a completed EC-1 to your employer within 30 days of your hire date. Your enrolled eligible dependents' coverage is effective the same date as yours.

Although **your coverage begins immediately**, payroll deductions for your premiums are not assessed sooner than the first day of the second pay period after your hire date. Regardless of when your payroll deductions begin, if you need to obtain services from any of the carriers, **you do not need to wait until you receive your ID cards**. The EUTF can arrange for you to receive them or you can ask your provider to delay submitting the claim for payment until your application has been processed and the carrier has recorded your enrollment. If your payroll deductions do not begin with your second pay period, they will be retroactive to your second pay period when they do begin.

If you were enrolled in the EUTF with your previous public employer and your coverage is still in effect on the day you begin work with your current employer (COBRA coverage excluded), your coverage begins immediately - so you have no break in coverage. (See Transfer of Employment, below.)

Coverage changes involving the addition of dependents are effective retroactive to the date of the event or the date the Fund receives proper notification, depending on the event and providing that the application is filed within 30 days of the event. Deletion of dependents is effective on a timely or prospective basis, depending upon receipt of the application by the EUTF. Dependent children are automatically terminated as of the end of the pay period they attain age 19 or 24, in the case of full-time students, and do not require the completion of an application to delete coverage. If your student graduates or drops out of school before age 24, your student becomes ineligible and you must submit an EC-1 to remove the student from coverage.

Transfer of Employment

If you transfer from one EUTF employer to another, including transfers within State and/or County employment, coverage will be continued provided that you are still covered by the EUTF (COBRA coverage excluded) when you begin in your new position.

If you transfer employment within 90 calendar days of the last day of employment with the previous employer, you will not be subject to Act 217, SLH 1995 as amended. Act 217 states that the employer contribution for retiree benefits will be determined as follows:

- If you were employed prior to July 1, 1996 and retire with 10 or more years of service, excluding sick leave, you will receive 100% employer contribution funding.
- If you were employed or re-employed more than 90 days after the last day worked with the previous employer, after June 30, 1996 with less than 10 years of service, the funding of your retiree benefits will be:

Years of Service, Excluding Sick Leave	Employer Funding
10 but fewer than 15	50%
15 but fewer than 25	75%
25 or more	100%

End of Coverage

Coverage for you and your dependents will end if:

1. You voluntarily terminate coverage.
2. Your employment terminates.
3. Your hours are reduced so you no longer qualify for coverage.
4. You do not make required premium payments.
5. You die except for certain exceptions.
6. Your employer ceases to participate in the EUTF.
7. The EUTF is discontinued.

Coverage for your dependents will end if:

1. Your dependent is no longer eligible for coverage.
2. Your enrolled dependent enters the uniformed services.

Effective Date of Termination

In general, coverage ends on the first day of the pay period after the event giving rise to the end of coverage. There may be certain instances in which the effective date is different such as a divorce, when coverage ends on the date the EUTF receives notification of the divorce. You may obtain additional information from your DPO or by referring to the EUTF Administrative Rules that are posted on the EUTF website, www.eutf.hawaii.gov.

Enrollment in EUTF benefit plans is contingent on meeting all eligibility criteria outlined on the previous pages and detailed in the Administrative Rules. Any enrollment application may be rejected if it is incomplete or does not contain all information required to be provided by the employee-beneficiary.

An enrollment application shall be rejected if:

1. The application seeks to enroll a person who is not eligible to enroll in the benefit plan for which enrollment is requested;
2. The application is not filed within the time limitations prescribed by the rules;
3. The application contains an intentional misstatement or misrepresentation of a material fact or contains other information of a fraudulent nature;
4. The employee-beneficiary owes past due contributions or other amounts to the Fund; or
5. Acceptance of the application would violate applicable federal or state law or any other provision of the rules.

Employee-beneficiaries will be notified of the rejection of any enrollment application.

Administrative Appeals

A person aggrieved by one of the following decisions by the Fund may appeal to the board for relief from that decision:

1. A determination that the person is not an employee-beneficiary, dependent-beneficiary or qualified beneficiary, or that the person is not eligible to enroll in or be covered by a benefit plan offered or sponsored by the Fund;
2. A determination that the person cannot make a change in enrollment, a change in coverage, or a change in plans;
3. A cancellation or termination of the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the Fund; or
4. A refusal to reinstate the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the Fund.

The first step in the appeal process is an appeal to the administrator. In order to appeal to the administrator for relief, an aggrieved person must file a written appeal in the Fund's office within thirty days of the date of the decision with respect to which relief is requested. The written appeal shall be filed in duplicate. Unless otherwise provided by applicable federal or state law, neither the administrator nor the board shall be required to hear any appeal that is filed after the thirty-day period has expired. The written appeal need not be in any particular form but should contain the following information:

1. The aggrieved person's name, address, and telephone number;

2. A description of the decision with respect to which relief is requested, including the date of the decision;

3. A statement of the relevant and material facts; and

4. A statement as to why the aggrieved person is appealing the decision, including the reasons that support the aggrieved person's position or contentions.

If the aggrieved person is dissatisfied with the administrator's action or if no action is taken by the administrator on the aggrieved person's written appeal within ninety days of its being filed in the Fund's office, the second step in the appeal process is for the aggrieved person to file a written appeal to the board. A written appeal to the board must be filed in duplicate in the Fund's office. The written appeal need not be in any particular form but shall contain the following information:

1. The aggrieved person's name, address and telephone number;

2. A statement of the nature of the aggrieved person's interest, e.g., employee-beneficiary or dependent-beneficiary;

3. A description of the decision with respect to which relief is requested, including, the date of the decision;

4. A complete statement of the relevant and material facts;

5. A statement of why the aggrieved person is appealing the decision, including a complete statement of the position or contentions of the aggrieved party; and

6. A full discussion of the reasons, including any legal authorities, in support of the aggrieved party's position or contentions.

Subject to applicable federal and state law, the board may reject any appeal that does not contain the foregoing information.

The board at any time may request the aggrieved person or any other party to the proceeding to submit a statement of additional facts or a memorandum, the purpose of which is to clarify the party's position or a specific factual or legal issue.

The board shall grant or deny the appeal within a reasonable amount of time. The board shall not be required to hold a hearing on any appeal unless otherwise required by applicable federal or state law. If required to hold a hearing, or if it decides to voluntarily hold a hearing on an appeal, subject to applicable federal or state law, the board may set such hearing before the board, a special, or standing committee of the board, a hearings officer, or any other person or entity authorized by the board to hear the matter in question. Nothing in these rules shall require the board to hear or decide any matter that can be lawfully delegated to another person or entity for a hearing and decision.

At any time, an aggrieved person may voluntarily waive his or her rights to the administrative appeal provided by the Rule by submitting such a waiver in writing to the Fund's office. The board may require the aggrieved person to make such a waiver by signing a form prescribed by it.

State of Hawaii Employees Only

By electing to participate in the Premium Conversion Plan (PCP), please note that:

1. Your authorization will automatically continue year-to-year for the duration of the plan until you change or canel your participation in the PCP during the Open Enrollment period or as provided under number 2 below.

2. If you have an allowable change in status (marriage, birth or adoption of children, divorce, etc.), you must complete/file all the required PCP forms within 90 days of the event, to change or cancel your reduction in pay (otherwise, changes cn be made only during the Open Enrollment period). Please note that you must notify the EUTF within 30 days of the event in order to make the change in coverage.

3. Allowable changes/cancellations will generally take effect the month after you file, so to avoid the risk of losing money, you need to file the forms as soon as possible. Changes in pre-tax payroll deductions are always done after receipt of the PCP-2 form; never retroactively.

4. Your election, in the absence of an allowable change in status, cannot be changed for the current plan year.

5. If you change/cancel your health insurance plan coverage, but your PCP change/cancellation is not allowable, your PCP authorization will still remain in effect through the end of the plan year, and your payments will be forfeited, until PCP change/cancellation forms are filed and approved during the next Open Enrollment period.

Enrollment Form Instructions

A. Print or type clearly, if form is unreadable it may be sent back to you.

B. **Please submit form to your Personnel Office or Department Personnel Officer (DPO) for verification.**

C. **This form is to be used for effective dates beginning July 1, 2004 or later. Do not use this form for events prior to July 1,2004.**

D. Sections:

1. Event – DPO, please describe the event. For example, Open Enrollment, Birth, Marriage, Divorce, Loss Coverage, Termination, Transfer In, Transfer Out, Address Chg, Marital Status Chg, Retire, Rehire, New Hire, Death, Student, Add Dep, Cancel etc. If there are simultaneous events, please describe the most prevalent event. For example, if the event is a birth and address change, enter Birth in the event section.
2. Event Date – DPO, please enter the date the event took place or 7/1/04 for Open Enrollment 2004.
3. Enter Employee's information for: Last Name, First Name, M.I., Social Security No., Mailing Address, City, State, Zip Code, Marital Status, Gender, Birth Date and Daytime/Evening Phone Number in the appropriate spaces.
4. Enter Social Security Number of Spouse or Domestic Partner and check appropriate box.
5. Check add box to add dependent, check delete box to delete dependent.
6. Enter Employee's Dependent(s) Name, Birth date, and SSN.
   If listing more than 5 dependents, write "Continued" on the last line of the Dependent section. Use a separate of paper to list additional dependent(s) information.
7. Use the following codes for Relationship column:
   SP = Spouse **CH** = Child **DC** = Disabled Child√√
   DP = Domestic Partner√ **DPC** = Domestic Partner Child√

For Relationship codes with √ or √√, please see item #17 below for other required forms.

8. Gender – circle either M or F.
9. Plan Selections (See Reference Guide for Plan Coverage Details). For Dual Medical plan coverage details see your personnel office or visit the EUTF website. Select only 1 box from each Plan Section.
   If you are selecting Medical Dual, Vision Dual or Dental Dual, you must have other coverage from another source outside of EUTF.
10. PCP – this section is for <u>State employees only.</u> Select Enroll, Do Not Enroll, Change amount, or Cancel. PCP is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pre-tax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. The PCP-2 form is not required for Open Enrollment. For all other qualifying events, please inquire with your DPO or DHRD on completing a PCP-2 form. (See the Reference Guide for Active Employees for details on PCP).
11. Comments – use this section for your comments
12. **Certification**
    Signature of Employee certifies that the information provided in this application is true and complete. Employee agrees to abide by the terms and conditions of the benefit plans selected. Employee authorizes their employer or finance officer to set the effective dates of coverage and to make the pre-tax or after tax deductions, adjustments or cancellations from employee's salary, wages, pension or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.
    Employee affirms that any listed dependent child, aged 19 through 23, is attending a college, university or technical school as a full-time student. Employee affirms that they have non-EUTF plan benefits for each Dual Coverage Plan selected. Employee signature also affirms that they have read and understood the PCP section in the Reference Guide for Active Employees.
    Please enter date of Employee's signature.
13. DPO signature certifies applicant is eligible as defined in Chapter 87A, HRS. <u>Enter date you received EC1 from your employee.</u> DPO – Please provide your phone and fax numbers.
14. Department ID code – DPO, please enter your appropriate Department ID code. For example, 010021 for Department of Education, 010022 for University of Hawaii, 040028 for City and County of Honolulu Emergency Services, etc.
15. Dept: and Division/School: - Optional fields for DPO use only.
16. Bargaining Unit number – DPO, please enter the appropriate bargaining unit for this employee.
17. Other EUTF forms to include with EC-1 (if applicable):
    √Domestic Partnership Declaration or Termination
    √Domestic Partner PCP Acknowledgement Form (State Employees with PCP enrolling Domestic Partners)
    √Affidavit of "Dependency" for Tax Purposes (For Domestic Partnerships)
    √√D-1 (5/2003) for enrolling disabled child
    AETNA Life Insurance Designation of Beneficiary (If enrolling for the first time or changing beneficiaries)

Keep a copy for your reference

Form EC-1 Revised July 2004

EC-1

Hawaii Employer-Union Health Benefits Trust Fund

ENROLLMENT FORM FOR ACTIVE EMPLOYEES

1. Event:

2. Event Date: (MM/DD/YY)

See Instructions on reverse side BEFORE completing this form. Refer to your reference guide or our website for plan details.

3a. Employee's Last Name, First, M.I.

3b. Social Security Number:

3c. Mailing Address:

3g. Marital Status:
❑ Married ❑ Single

3i. Birth Date: (MM/DD/YY)

3d. City:

3f. Zip Code:

3h. Gender:
❑ Male ❑ Female

3j. Phone Number – Work

4. Social Security Number of Spouse or Domestic Partner
___ ___ ___ / ___ ___ / ___ ___ ___ ___

❑ State or County - Employee or Retiree
❑ Other – Private, Federal ,etc.

3k. Phone Number – Home

5a. Add	5b. Delete	6a. Dependents: First Name, M.I., Last Name (if different)	6b. Birth Date (MM/DD/YY)	6c. Social Security Number	7. Relationship	8. Gender
❑	❑					M F
❑	❑					M F
❑	❑					M F
❑	❑					M F
❑	❑					M F

9. Plan Selections, Changes or Cancellations - Make your selection by checking the box for the appropriate benefit plans below. Select either Self, Family or Cancel/Waive coverage. Choose only one box in each plan section.

Plan Section	*Carrier Selection*	*Self*	*Family*	*Cancel/Waive*
Medical/Drug, Chiropractic (choose Self, Family or Cancel/Waive)	HMSA PPO Medical and Drug, MBAH ChiroPlan	❑	❑	❑
	Kaiser Medical and Drug, MBAH ChiroPlan	❑	❑	
	HMSA Dual Coverage Medical/Drug, Chiropractic (I have medical/drug coverage from another source outside of EUTF)	❑	❑	
	Royal State Dual Coverage Medical/Drug, Chiropractic (I have medical/drug coverage from another source outside of EUTF)	❑	❑	
	HMSA Prescription Drug Only (Cannot be combined with any plan listed above)	❑	❑	
Dental (choose Self, Family or Cancel/Waive)	HDS Dental	❑	❑	❑
	HDS Dual Coverage Dental (I have dental coverage from another source outside of EUTF)	❑	❑	
Vision (choose Self, Family or Cancel/Waive)	VSP Vision	❑	❑	❑
	VSP Dual Coverage Vision (I have vision coverage from another source outside of EUTF)	❑	❑	
AETNA Life Insurance Plan		❑		❑

10. **State Employees ONLY (Premium Conversion Plan)** ❑ Enroll ❑ Do NOT Enroll ❑ Change amount ❑ Cancel PCP

11. Comments:

12. Certification (see instructions on back of this form)

Employee Signature: _____ **Date:** _____

13. DPO Signature: _____ Date: _____ DPO Phone: _____ DPO FAX: _____

14. Dept. ID# ___ ___ ___ ___ ___ ___	15a. Dept:	15b. Division/ School:	16. Barg. Unit:

EC1

SUBMIT TO YOUR PERSONNEL OFFICE

Form EC-1 Revised July 2004

Medical - PPO Plan

The medical PPO plan is offered through HMSA. This summary is intended to provide a condensed explanation of plan benefits and provisions, please refer to the Guide to Benefits or certificate, which may be obtained by calling HMSA or from the EUTF website, www.eutf.hawaii.gov. In the case of a discrepancy between this summary and the language contained within the Guide to Benefits, the Guide to Benefits will take precedence.

If you have questions, please contact HMSA at any of the following locations:

Oahu	818 Keeaumoku Street Honolulu, HI 96814 Phone: (808) 948-6499	
Hawaii	670 Ponahawai Street, Suite 121 Hilo, HI 96720 Phone: (808) 935-5441	75-166 Kalani Street, Suite 202 Kailua-Kona, HI 96740 Phone: (808) 329-5291
Kauai	4366 Kukui grove Street, Suite 202 Lihue, HI 96766 Phone: (808) 245-3393	
Maui	33 Lono Avenue, Suite 350 Kahului, HI 96732 Phone: (808) 871-6295	

You may also find answers to your questions at the HMSA website, www.hmsa.com.

Beneficiaries who were covered by HMSA immediately prior to electing this coverage will have previously accrued maximums carry forward and count against the same types of maximum amounts under this coverage.

This medical coverage is combined with benefits for prescription medicines. This section summarizes these benefits.

Lifetime Maximum	$2,000,000	
Maximum Annual Co-payment	$1,500 per person	$4,500 per family
	Participating Provider	**Nonparticipating Provider**
Annual Deductible	None	$100 per person/$300 per family
	Co-payment Is	
Physician Visits	10%	30% after annual deductible
Immunizations including Hepatitis B	None	None
Testing, Laboratory and Radiology[(1)] Includes Allergy Testing, Allergy Treatment Materials, Inpatient and Outpatient Diagnostic Testing and Radiology, and Tuberculin Skin Test.	10%	30% after annual deductible
Note: [(1)] HMSA may contract with certain laboratory and radiology groups to accept HMSA's payment as payment in full. Members may not have a copayment for services received as part of these types of contractual arrangements.		
Surgical Services	10%	30% after annual deductible
Transplant Evaluation	None	Not Covered
Chemotherapy and Radiation therapy	10%	30% after annual deductible

HMSA Blue Cross Blue Shield of Hawaii
An Independent Licensee of the Blue Cross and Blue Shield Association

	Co-payment Is	
	Participating Provider	**Nonparticipating Provider**
Hospital and Facility Services		
Ambulatory Surgical Center (ASC)	10%	30% after annual deductible
Emergency Room	10%	10%
Inpatient Hospital Services	10%	30% after annual deductible
Skilled Nursing Facility	10%	30% after annual deductible
Behavioral Health - Mental Health and Substance Abuse		
Mental Health Facility Services	10%	30% after annual deductible
Mental Health Physician Services – Inpatient	10%	30% after annual deductible
Psychological Testing – Inpatient & Outpatient	10%	30% after annual deductible
Substance Abuse Facility Services	10%	30% after annual deductible
Substance Abuse Physician Services Inpatient	10%	30% after annual deductible
Other Medical Services and Supplies	10%	30% after annual deductible
Medical Foods	10%	20%
Private Duty Nursing	Not Covered	Not Covered
Cardiac Rehabilitation	Not Covered	Not Covered
Organ and Tissue Transplants HMSA has contracted with certain providers for the following transplant services. You must receive services from a contracted provider for these benefits to apply. Corneal, Kidney, Small Bowel, Small Bowel/Liver	None	Not Covered
Special Benefits for Disease Management		
Asthma Care Connection	None	Not Covered
Behavioral Care Connection	None	Not Covered
Cardiac Care Connection	None	Not Covered
Diabetes Care Connection	None	Not Covered
Special Benefits for Health Assessment and Health Education		
RSVP Screenings Limitations apply.	10%	30% after annual deductible
HealthPass – health and weight measurements, body fat analysis, blood pressure measurements, blood cholesterol, HDL, and glucose screening	None	Not Covered
Health Appraisal Program (2) **-** Laboratory and X-ray Services & Physical Exams	None	Not Covered
Physical Examinations (2) - Routine annual checkup	Any amount exceeding HMSA's allowance of up to $41.50 ages 6 – 12 years $62 ages 13 – 18 years $113.50 ages 19 – 39 years $170.00 ages over 40 years	Any amount exceeding HMSA's allowance of up to $41.50 ages 6 – 12 years $62 ages 13 – 18 years $113.50 ages 19 – 39 years $170.00 ages over 40 years

Note: (2) Coverage includes benefits for either one Health Appraisal Program or one Physical Exam per calendar year.

Prescription Drug-Only Plan Benefits

HMSA Blue Cross Blue Shield of Hawaii
An Independent Licensee of the Blue Cross and Blue Shield Association

BENEFITS	MEMBER PAYS	
RETAIL PRESCRIPTION PROGRAM (30 day supply)	**Participating Pharmacy**	**Nonparticipating Pharmacy**
Generic	$5 copayment	$5 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Preferred Brand Name	$15 copayment	$15 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Other Brand Name	$30 copayment	$30 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Insulin		
Preferred Insulin	$5 copayment	$5 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Other Insulin	$15 copayment	$15 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Diabetic Supplies		
Preferred Diabetic Supplies	No copayment	No copayment
Other Diabetic Supplies	$15 copayment	$15 copayment
Oral Contraceptives		
Preferred Oral Contraceptives	$5 copayment	$8 copayment
Other Oral Contraceptives (including generic contraceptives)	$30 copayment	$30 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Diaphragms		
Preferred Diaphragms	$10 copayment	$12 copayment
Other Diaphragms	$20 copayment	$20 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Spacers[(1)]	Special Member Rates	Special Member Rates
Peak Flow Meters[(1)]	Special Member Rates	Special Member Rates
Note: [(1)] HMSA has arranged with contracted drug manufacturers to offer spacers for inhaled drugs and peak flow meters at special member rates.		
MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)	**HMSA Vendor**	**Non-HMSA Vendor**
Generic	$10 copayment	Not a benefit
Preferred Brand Name	$35 copayment	Not a benefit
Other Brand Name	$60 copayment	Not a benefit
Insulin		
Preferred Insulin	$10 copayment	Not a benefit
Other Insulin	$35 copayment	Not a benefit
Diabetic Supplies		
Preferred Diabetic Supplies	No copayment	Not a benefit
Other Diabetic Supplies	$35 copayment	Not a benefit

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This is only a summary. It does not fully describe your benefit coverage. For details on your benefit coverage, exclusions, and plan terms, please refer to your employer's applicable Face Sheet, Group Medical and Hospital Service Agreement, Benefit Schedule, and Riders (collectively known as "Service Agreement"). The Service Agreement is the legal binding document between Health Plan and its members.

You are covered for medically necessary services, within the Hawaii service area, at Kaiser Permanente facilities, and which are provided or arranged by a Kaiser Permanente physician. All care and services need to be coordinated by a Kaiser Permanente physician. For specific questions about coverage, please ask your employer's benefits officer or call the Customer Service Center at (808) 432-5955 (Oahu) or 1-(800) 966-5955 (Neighbor Islands).

	Benefits	You pay
Outpatient services	**Doctors' and other health practitioners' office visits**	$10 registration fee per visit
	Preventive care Health evaluations for adults Physical examinations for children, and well-baby care	$10 registration fee per visit
	Immunizations generally available in the Hawaii service area:	
	Immunizations developed and in general use for specific diseases on March 1, 1994	No charge
	- Exception: Hepatitis B for adults and children 6 years of age and under	50% of applicable charges
	Immunizations developed or in general use for specific diseases after March 1, 1994	50% of applicable charges
	- Exception: Immunizations in keeping with "prevailing medical standards" (as defined by State law) for children 5 years of age or under	No charge
	Unexpected mass immunizations	50% of applicable charges
	Injectable travel immunizations	50% of applicable charges
	Oral travel immunizations	$10 per prescription
	Laboratory procedures, prescribed imaging, and diagnostic services	No charge
	Radiation therapy	$10 registration fee per visit
	Visits to receive radioisotopes for the treatment of cancer	$10 registration fee per visit
	Eye examinations for eyeglasses	$10 registration fee per visit
	Respiratory therapy	$10 registration fee per visit
	Short-term physical, occupational and speech therapy (up to 2 months per condition and only if have significant improvement in physical function)	$10 registration fee per visit
	Dialysis - Kaiser Permanente physician and facility services for dialysis	$10 registration fee per visit
	Equipment, training and medical supplies for home dialysis	No charge
	Outpatient surgery and procedures	$10 registration fee per visit
	Materials for dressings and casts	No charge after $10 registration fee
	Take-home supplies, such as drug and ostomy supplies, catheters and tubing	**Not covered**
Hospital inpatient care	**Doctors' medical and surgical services**	No charge
	Room and board, general nursing, laboratory procedures, prescribed imaging, and diagnostic services	No charge

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	Benefits	You pay
Hospital inpatient care cont.	**Transplants**, including kidney, heart, heart-lung, liver, lung, simultaneous kidney-pancreas, bone marrow, cornea, small bowel, and small bowel-liver transplants	No charge for the procedure (drugs according to member's drug coverage)
Prescribed drugs	**Prescribed drugs that require skilled administration by medical personnel** (e.g. cannot be self-administered) which are prescribed by a Kaiser Permanente licensed prescriber, on the Health Plan formulary, and used in accordance with formulary criteria, guidelines or restrictions, prescription is required by law, and one-time medication administered incident to the visit, or is a training/test dose given prior to self-administration **Exclusions:** Drugs that are necessary or associated with services that are excluded or not covered	No charge after $10 registration fee
Prenatal care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services	**Prenatal care** (prenatal care, delivery, and mother's care in the hospital following delivery) doctor's services, laboratory procedures and hospital inpatient care	No charge after confirmation of pregnancy
	Interrupted pregnancy and family planning services	$10 registration fee per visit
	Involuntary infertility services (not including lab, prescribed imaging or drugs)	$10 registration fee per visit
	Artificial insemination	$10 registration fee per visit
	In vitro fertilization - limited to one-time only benefit at Kaiser Permanente limited to female members using spouse's sperm	20% of applicable charges (drugs according to member's drug coverage)
Home health care and hospice care	**Home health care**, nurse and home health aide visits to homebound members, when prescribed by a Kaiser Permanente physician. **Hospice care**. Supportive and palliative care for a terminally ill member, as directed by a Kaiser Permanente physician. Hospice coverage includes two 90-day periods, followed by an unlimited number of 60-day periods. The member must be certified by a Kaiser Permanente physician as terminally ill at the beginning of each period. (Hospice benefits apply in lieu of any other plan benefits for treatment of terminal illness.)	No charge
Skilled nursing care	Up to **100 days of prescribed skilled nursing care services in an approved facility** (such as a hospital or skilled nursing facility) **per benefit period**. **Exclusions:** Personal comfort items, such as telephone, television and take-home medical supplies.	No charge
Emergency services (covered for initial emergency treatment only)	At a facility <u>within</u> the Hawaii service area for covered emergency services	$25 registration fee per visit, plus other applicable plan charges
	At a facility outside the Hawaii service area for covered emergency services	20% of all Reasonable and Customary charges plus other applicable plan charges
	Note: Member (or Member's family) must notify Health Plan within 48 hours if admitted to a non-Kaiser Permanente facility.	
Out-of-area urgent care services	At a non-Kaiser Permanente facility for covered urgent care services (Coverage for initial urgent care treatment only and while temporarily outside the Hawaii service area)	20% of all Reasonable and Customary charges plus other applicable plan charges

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	Benefits	You pay
Ambulance services	Ambulance Services are those services in which: use of any other means of transport, regardless of availability of such other means, would result in death or serious impairment of the member's health, and is for the purpose of transporting the member to receive medically necessary acute care. In addition, air ambulance must be for the purpose of transporting the member to the nearest medical facility designated by the Health Plan for receipt of medically necessary acute care, and the member's condition must require the services of an air ambulance for safe transport.	20% of all Reasonable and Customary charges
Blood (inpatient or outpatient)	Regardless of replacement, units and processing of units of whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin. Collection, processing, and storage of **autologous blood** when prescribed by a Kaiser Permanente physician.	20% of applicable charges
	Donor directed units	Not covered
Mental health and chemical dependency services	Up to 24 combined outpatient office visits/calendar year	$10 registration fee per visit
	Mental Health - Up to 30 days hospital care per calendar year in total, which can include any combination of hospital days and specialized facility services. (Two (2) days of specialized facility care counts as one (1) hospital day.) Includes Kaiser Permanente physician services	No charge
	Chemical Dependency - Up to 30 days hospital care per calendar year in total, which can include any combination of hospital days and specialized facility services. (Two (2) days of specialized facility care counts as one (1) hospital day.) Includes Kaiser Permanente physician services	20% of applicable charges
	Note: Parity coverage for "serious mental illness" (schizophrenia, schizo-affective disorder, and bipolar type I and II), is provided in accordance with state law.	
Internal prosthetics, devices, and aids	**Implanted internal prosthetics** (such as pacemakers and hip joints), **and internally implanted devices and aids** (such as surgical mesh, stents, bone cement, implanted nuts, bolts, screws, and rods) which are medically indicated, prescribed by a Kaiser Permanente physician and obtained from sources designated by Health Plan	20% of applicable charges
External prosthetic devices and braces	**External prosthetic devices and braces,** when prescribed by a Kaiser Permanente physician, and obtained from sources designated by Health Plan	20% of applicable charges
Durable medical equipment	Medically necessary and appropriate **durable medical equipment for use in the home,** when prescribed by a Kaiser Permanente physician and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan	20% of applicable charges
	Oxygen for use in conjunction with prescribed durable medical equipment	20% of applicable charges
Diabetes equipment	**Glucose meters and external insulin pumps** (and the supplies necessary to operate them) when Health Plan criteria are met.	20% of applicable charges

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	Benefits	You pay
Drug	For each prescription, when the quantity does not exceed: a 30–consecutive-day supply of a prescribed drug, or one dose of a self-administered injectable drug, or one cycle of an oral contraceptive drug, or an amount as determined by the Formulary.	$10 per prescription
	Insulin and certain diabetes supplies	$10 per prescription
	Oral contraceptive drugs	$10 for one cycle
	Diaphragms and cervical caps	$10 each
	Other contraceptive drugs and devices	$10 times the number of months the drug or device is effective; $250 maximum
Mail order	Mail order prescription forms may be obtained at any Kaiser Permanente pharmacy, or call the Kaiser Permanente mail order pharmacy at 432-5510, Monday - Friday, 8:30 A.M. to 5:00 P.M. You may purchase a 3 month's supply of maintenance medications at 2 copayment amounts through Kaiser Permanente's mail order prescription service, restricted to ZIP codes in the Kaiser Permanente service area. Please mail your refill order before you are down to your last 10 days supply. Allow one week to receive your medication for refillable orders. The mail order program does not apply to the delivery of certain pharmaceuticals (i.e., controlled substances as determined by State and/or Federal regulations, bulky items, medication affected by temperature, injectables, and other products and dosage forms as identified by the Pharmacy and Therapeutics Committee). Mail order drugs will not be sent to addresses outside the State of Hawaii.	$20 for 3 prescriptions
Supplemental charges maximum	**Your out-of-pocket expenses for covered Basic Health Services are capped each year by a Supplemental Charges Maximum.**	$1,500 per member, $4,500 per family unit (3 or more members), for calendar year

You must retain your receipts for the charges you have paid, and when the maximum amount has been PAID, you must present these receipts to our Business Office at Moanalua Medical Center, Honolulu Clinic or to the cashier at other clinics. After verification that the Supplemental Charges Maximum has been PAID, you will be given a card which indicates that no additional Supplemental Charges for covered Basic Health Services will be collected for the remainder of the calendar year. You need to show this card at your visits to get your Supplemental Charges waived.

All payments are credited toward the calendar year in which the services were received.

Once you have met the Supplemental Charges Maximum, please submit your proof of payment as soon as reasonably possible. All receipts must be submitted no later than February 28 of the year following the one in which the services were received.

This is only a summary. It does not fully describe your benefit coverage **nor does it list the majority of the exclusions and limitations for these benefits**. For a summary listing of the benefit exclusions and limitations, please contact the Kaiser Permanente's Customer Service Department. For a full description of your benefit coverage, exclusions, and plan terms, please refer to your employer's applicable Face Sheet, Group Medical and Hospital Service Agreement, Benefit Schedule, and Riders (collectively known as "Service Agreement"). The Service Agreement is the legal binding document between Health Plan and its members. In event of ambiguity, or a conflict between this summary and the Service Agreement, the Service Agreement shall control.

Except for certain situations outlined in the Service Agreement, all claims, disputes, or causes of action arising out of or related to the Service Agreement, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes, or causes of action subject to binding arbitration, all parties give up the right to jury or court trial. For a complete description of arbitration information, please see the Service Agreement.

Dual-Coverage Medical Benefits

Active Employees who have medical coverage through private sector or federal government plans have the option to select a dual-coverage medical plan as a supplement. Active employees have a choice between dual-coverage benefits offered by HMSA and the Royal State National Insurance Company Limited. Summaries of the benefits offered by each carrier follow.

HMSA Dual-Coverage Medical and Prescription Benefits

The following summarizes the benefits offered in this plan. This summary is intended to provide a condensed explanation of plan benefits. For complete information please refer to the Guide to Benefits which may be obtained by calling HMSA or from the EUTF website www.eutf.hawaii.gov. In the case of a discrepancy between this Summary and the language contained within the Guide to Benefits, the Guide to Benefits will take precedence.

Medical Benefits	**Plan Provisions**	
Annual Deductible	None	
Hospital Deductible	None	
Lifetime Maximum Benefit	$1,000,000 per person	
Maximum Annual Co-Payment	$10,000 per person	
	Plan Pays	
	Participating Provider	**Non-Participating Provider**
Physician's Services		
Office Visit	50%	50%
Well Child Care	100%	50%
Well Woman Exam	100%	50%
Surgical Services	50%	50%
Maternity Care	50%	50%
Immunizations		
Standard	50%	50%
Well Baby	100%	100%
Well Child	100%	100%
Hospital Services		
Room, Ancillary Services	50%	50%
Skilled Nursing Facility	50%	50%
Ambulatory Surgical Center	50%	50%
Emergency room	50%	50%
X-Ray & Lab Testing	50%	50%
Allergy Testing/Materials	50%	50%
Pap Smear, PSA, Screening Mammography	100%	50%
Radiation/Chemotherapy	50%	50%
Organ/Tissue Transplants		
Cornea, kidney, small bowel, small bowel/liver	50%	50%

	Plan Pays	
	Participating Provider	**Non-Participating Provider**
Organ/Tissue Transplants cont.		
Bone marrow, heart, lung, kidney-pancreas, liver	100%	Not Covered
Mental Health/Substance Abuse		
Inpatient Days Per Year	30	30
Outpatient visits per year[1]	12	24
Hospital/Facility Services	Regular Plan Benefits	
Physician Services	Regular Plan Benefits	
Terminal/Long Term Care		
Home Health Care	50%	50%
Hospice	100%	Not Covered
Other Medical Services		
Ambulance, blood, dialysis, appliances/equipment, injections	50%	50%
Physical, occupational and speech therapy	50%	50%
Medical Foods	80%	80%
Special Benefits for Health Assessment, Health Education and Disease Management		
Health Pass; Asthma Care, Behavioral Care, Diabetes Care and Cardiac Care Connections	None	Not Covered

[1] Twelve (12) visits must be used for mental health services. Limitations do not apply to serious medical illness in accordance with Hawaii law.

Note: HMSA may contract with certain laboratory and radiology groups to accept HMSA's payment as payment in full. Members may not have a copayment for services received as part of these contractual arrangements.

The following summarizes HMSA's dual coverage prescription drug benefits.

BENEFITS	**MEMBER PAYS**	
RETAIL PHARMACY (30 day supply)	**Participating Pharmacy**	**Nonparticipating Pharmacy**
Generic, Preferred Brand Name, Other Brand Name, Insulin, Diabetic Supplies, Oral Contraceptives, Diaphragms	Any eligible charges exceeding HMSA's payment of $15	Any charges exceeding HMSA's payment of $15
Spacers(1) and Peak Flow Meters(1)	Special Member Rates	Special Member Rates
Note: (1) HMSA has arranged with contracted drug manufacturers to offer spacers for inhaled drugs and peak flow meters at special member rates.		
MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)		
Generic, Preferred Brand Name, Other Brand Name, Insulin, Diabetic Supplies	Any eligible charges exceeding HMSA's payment of $30	Not a benefit

Royal State National Insurance Company, Limited
Dual Coverage Benefits

The Royal State National dual-coverage benefits plan reimburses the member's out-of-pocket costs paid for medical care up to the maximum amount per month shown below. Medical care means the diagnosis, cure, mitigation, treatment or prevention of disease, prescribed drugs, and treatments affecting any part or function of the body. Medical care must be primarily to alleviate or prevent a physical or mental defect or illness, and includes limited amounts paid for transportation to get medical care. Only expenses for medical care, which the member has paid, and which costs are not recoverable from any other person including any insurance policy, are eligible for reimbursement under the Royal State National dual-coverage benefits plan.

This summary describes plan highlights only. Please refer to Plan Certificate and Master Policy for benefit details, limitations and exclusions.

Plan Provisions	
Annual Deductible	Not Applicable
Annual Copayment Maximum	Not Applicable
Maximum Reimbursement Per Month	
Bargaining Units 01, 10, 20, 33, 61, 70 & 90	
Single Coverage	$138.00
Family Coverage	$329.00
All Other Bargaining Units	
Single Coverage	$40.00
Family Coverage	$125.00

Medical Care Expenses Eligible for Reimbursement		
Acupuncture	Drug addiction treatment	Massage therapy
Ambulance	Eyeglasses	Medical services
Appliances/medical equipment	Eye surgery	Nutritional supplements
Birth control pills	Fertility enhancement	Prescription drugs
Chiropractic care	Hospital services	Surgical services
Contact lenses	Laboratory and x-ray	Weight-loss program
Dental services	Learning disabilities	

Carryforward Benefit. The maximum reimbursement amount is per month as described above. If the out-of-pocket expenses for medical care are less than the monthly maximum amount, the unused benefit amount will be carried forward to future (subsequent) months, but no further than to the end of the plan year (June 30) or the date the dual-coverage plan is terminated, whichever is earlier. If the member's out-of-pocket expenses for medical care are greater than the monthly maximum amount, additional reimbursement for the same out-of-pocket medical care expenses may be paid in future (subsequent) months, but no more will be paid than the allowable monthly maximum amount, and no further than to the end of the plan year (June 30) or the date the dual-coverage plan is terminated, whichever is earlier.

Claim Submission Requirements

1. You are responsible to collect and keep all receipts or statements that show that you have paid out-of-pocket medical care expenses incurred during the plan year.

2. You must fill out a claim form approved by Royal State National and attach copy of all receipts or statements as proof of your out-of-pocket paid expenses. The dates of service must be clearly itemized with your out-of-pocket expense indicated. Your reimbursement is based on the date of service, not when the service was paid for. For additional rules and requirements, you must follow the Company's claim form instructions.
3. All services for out-of-pocket reimbursement must be received or incurred during the plan year.
4. Royal State National must receive your claim by the last day of a month in order to be processed for that month. If your claim is received after the last day of the month, your claim will be processed the following month.

Timely Submission of Claims Royal State National must receive your claims before the end of the 90-day period after the end of the plan year or after your termination date, whichever is earlier. The Plan will not pay any claims received after this 90-day period.

Payment of Benefits Approved claims shall be paid on monthly basis and after the close of the month All reimbursement payments are payable directly to you.

Plan Certificate and Claim Forms. The Company will mail you your plan certificate and claim form within 15 business days from the date the Company receives your enrollment information from the Hawaii Employer-Union Health Benefits Trust Fund. A new claim form will be enclosed with every reimbursement benefit payment to you. For additional claim forms or questions, please contact Royal State National at (808) 539-1621 or toll free 1-800-890-9022.

This summary is intended to provide a condensed explanation of plan benefits. Please refer to the respective plan brochures and certificates for complete information on benefits, provisions, limitations or exclusions. In the case of a discrepancy between these descriptions or comparisons and the language contained within the respective plan certificates, the latter will govern.

ChiroPlan Chiropractic Coverage

Mutual Benefit Association of Hawaii, through ChiroPlan Hawaii, Inc. is the provider of chiropractic benefits. The plan description provided in this summary of benefits shows highlights of the plan benefits. Please refer to the plan certificate for complete information on benefits, provisions, limitations and exclusions. In the errant case of a discrepancy between these descriptions and the provisions contained in the plan certificate, the latter will govern. A complete list of ChiroPlan doctors and plan information may be obtained from the EUTF website, www.eutf.hawaii.gov.

All three of the medical plan options (PPO, HMO or dual-coverage) described on the previous pages include these chiropractic benefits. In order to use these benefits you must use ChiroPlan doctors. ChiroPlan may be contacted at:

ChiroPlan Hawaii. Inc.
711 Kilani Avenue, Suite 3
Wahiawa, HI 96786
Telephone: 808-621-4774
Toll-free: 800-414-8845 (Neighbor Islands)
Fax: 808-621-0006
Website: www.chiroplanhawaii.com

	ChiroPlan Provider	**Non-ChiroPlan Provider**
Maximum # of Office Visits Per Year	20	Not Covered
Office Visit Copay	$15.00	Not Covered
Therapy Modalities*	No Charge	Not Covered
X-Ray**	No Charge	Not Covered
Lab	Not Covered	Not Covered
Chiropractic Appliances	Not Covered	Not Covered
Emergency/Urgent Care	Not Covered	Not Covered
Out-of-Network	Not Covered	Not Covered
Alternative Medical Services***	Not Covered	Not Covered

* Therapy Modalities Include: Ultrasound, Ice Packs, Heat Packs, Electrical Muscle Stimulation and other approved therapies.

** Routine x-rays: Two (2) views per body region, per calendar year; additional x-rays performed require a $15.00 co-pay (when performed in a ChiroPlan doctor's office).

*** Alternative Medical Services Includes: Hypnotherapy, Acupuncture, Behavior Training, Sleep Therapy, etc.

HDS Dental Plan

Summarized below are the dental benefits provided through Hawaii Dental Service (HDS). For a full description of the benefits and how to access them, refer to the EUTF website, www.eutf.hawaii.gov, or the HDS Customer Service Department at (808) 529-9248 or toll-free from the neighbor islands and continental U.S. at 1-800-232-2533 extension 248. You may also obtain information from the HDS website, www.deltadentalhi.org.

Benefit	Plan Coverage
Maximum Benefit Amount Per Calendar Year	$2,000/ person
Deductible Per Calendar Year (does not apply to benefits covered at 100%)	$25/ person
Diagnostic	
Examinations (twice per calendar year)	100%
Bitewing x-rays (twice per calendar year)	100%
Other x-rays (full mouth x-rays limited to once every three years)	100%
Preventive	
Prophylaxes (cleanings - twice per calendar year)	100%
Stannous fluoride (once per calendar year through age 17)	100%
Space maintainers (through age 17)	100%
Sealants (through age 16)	100%
One treatment application, once per lifetime only to permanent posterior molar teeth with no cavities and no occlusal restorations, regardless of the number of surfaces involved.	
Restorative	
Amalgam (silver-colored) fillings	80%
Composite (white-colored) fillings, limited to anterior (front) teeth	80%
Note: Composite restorations on posterior (back) teeth will be processed as the alternate benefit of an amalgam and the patient will be responsible for the cost difference up to the dentist's charged fee.	
Crowns and Gold Restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings)	60%
Note: Porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent and the patient will be responsible for the cost difference up to the dentist's charged fee.	
Endodontics	
Pulpal Therapy	80%
Root canal treatment, retreatment, apexification, apicoectomy	80%
Periodontics	
Periodontal scaling and root planing – once every two years	80%
Gingivectomy, flap curettage and osseous surgery - - once every three years	80%
Periodontal maintenance – twice per calendar year	80%
Prosthodontics	
Fixed Bridges (once every 5 years; ages 16 and older)	60%
Removable dentures (complete & partial – once every 5 years; ages 16 & older)	60%
Repairs, adjustments, relines and rebase	60%
Oral Surgery	
Extractions and other oral surgery procedures to supplement medical care plan	80%
Adjunctive General Services	
Consultations by Specialist not performing services	80%
Office visits (injury related)	80%
Sedation General and IV – Oral Surgery Only	80%
Palliative (Emergency) treatment (for relief of pain but not to cure)	100%

Benefit	Plan Coverage
Orthodontics Maximum amount payable by HDS for an eligible patient shall be $1,000 lifetime per case paid in 8 quarterly payments of $125. If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue. If the group removes the orthodontic benefit, coverage will end on the last day of the benefit change month.	50%

Shaded areas indicate coverage after 12 months of continuous enrollment.

Benefit Exclusions

Your HDS plan does not cover the following services:

- Services for injuries and conditions that are covered under Workers' Compensation or Employer's Liability Laws; services provided by any federal or state government agency or those provided without cost to the eligible person by the government or any agency or instrumentality of the government.
- Congenital malformations, medically related problems, cosmetic surgery or dentistry for cosmetic reasons.
- Procedures, appliances or restorations other than those for replacement of structure loss from cavities that are necessary to alter, restore or maintain occlusion.
- Vertical dimension, occlusal adjustment, equilibration, periodontal splinting, restoration of tooth structure lost from wearing away, restoration for tooth malalignment, jaw movement recordings and treatment of disturbances of the temporomandibular joint (TMJ).
- Orthodontic services if services were started prior to the date the patient became eligible under this group plan.
- Hawaii general excise tax imposed or incurred in connection with any fees charged, whether or not passed on to subscriber by a dentist.
- All other services not specified in the Schedule of Benefits, which is available from your employer.

Multi-state Coverage

If you or your family reside or travel outside Hawaii and need dental care, your HDS plan will provide you coverage. HDS is a member of Delta Dental Plans Association, the largest dental benefits provider in the nation. So if your job takes you out of state or your son or daughter attends school on the Mainland, the charges of participating dentists would be capped by their respective state's eligible fees for covered services.

While on the Mainland, you can maximize your benefits by selecting a dentist who participates with Delta Dental. To obtain a list of participating Delta dentists in that zip code, visit the Delta Dental web site at www.deltadental.com and use the 'Dentist Search' capability. Or you may call our Customer Service Department toll-free at (800) 232-2533 ext. 248 and we will send you a list of participating dentists in your area.

Visiting a Participating Delta Dentist

If the dentist you have selected is a participating HDS or Delta (on the Mainland) dentist, he/she will submit the claim directly to HDS for you. Be sure he/she obtains HDS's mailing address from the back of your member identification card. HDS's payment will be based upon the participating dentist's eligible fees in his/her state. (HDS uses the National Provider File to obtain these fees.) Your share will be limited to the difference between the participating dentist's eligible fee and HDS's payment amount.

Visiting a Non-Participating Dentist

When you visit a non-participating dentist, in most cases you will need to pay in full at the time of service. On your first visit to a non-participating dentist, advise the dentist that you have an HDS dental plan and present your HDS member identification card. Your dentist will render services and may send you the completed claim form (universal ADA claim form) to file with HDS. Mail the completed claim form to the following address for processing:

HDS - Dental Claims
700 Bishop Street, Suite 700
Honolulu, HI 96813-4196

HDS will pay for services rendered up to your benefits coverage amount. Please be aware that your non-participating dentist's fees may be higher than a participating dentist's fees, and the fees used to calculate your benefit are lower than participating dentists' eligible fees. You are responsible for the difference between your non-participating dentist's fees and HDS's payment amount.

Dual Coverage Dental Plan

As with the medical plan, you have the option to elect the Dual Coverage Dental plan if you have primary dental coverage from the private sector or federal government. This plan is also offered by HDS. Please refer to page 25 for contact information for HDS.

Benefit	Plan Coverage
Maximum Benefit Amount Per Calendar Year	$800/ person
Diagnostic	
Examinations (twice per calendar year)	50%
Bitewing x-rays (twice per calendar year)	50%
Other x-rays (full mouth x-rays limited to once every three years)	50%
Preventive	
Prophylaxes (cleanings - twice per calendar year)	50%
Stannous fluoride (once per calendar year through age 17)	50%
Space maintainers (through age 17)	50%
Sealants (through age 16)	50%
One treatment application, once per lifetime only to permanent posterior molar teeth with no cavities and no occlusal restorations, regardless of the number of surfaces involved.	
Restorative	
Amalgam (silver-colored) fillings	40%
Composite (white-colored) fillings, limited to anterior (front) teeth	40%
Note: Composite restorations on posterior (back) teeth will be processed as the alternate benefit of an amalgam and the patient will be responsible for the cost difference up to the dentist's charged fee.	
Crowns and Gold Restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings)	30%
Note: Porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent and the patient will be responsible for the cost difference up to the dentist's charged fee.	
Endodontics	
Pulpal Therapy	40%
Root canal treatment, retreatment, apexification, apicoectomy	40%
Periodontics	
Periodontal scaling and root planing – once every two years	40%
Gingivectomy, flap curettage and osseous surgery - - once every three years	40%
Periodontal maintenance – twice per calendar year	40%
Prosthodontics	
Fixed Bridges (once every 5 years; ages 16 and older)	30%
Removable dentures (complete & partial – once every 5 years; ages 16 & older)	30%
Repairs, adjustments, relines and rebase	30%
Oral Surgery	
Extractions and other oral surgery procedures to supplement medical care plan	40%
Adjunctive General Services	
Consultations by Specialist not performing services	40%
Office visits (injury related)	40%
Sedation General and IV – Oral Surgery Only	40%
Palliative (Emergency) treatment (for relief of pain but not to cure)	50%

VSP Vision Plan

Summarized below are the vision benefits provided through Vision Service Plan (VSP). For a full description of the benefits and how to access them, refer to the EUTF website, www.eutf.hawaii.gov, or the VSP Customer Service Department at 808-532-1600 or toll-free from the neighbor island at 800-522-5162 and continental U.S. at 800-877-7195. You may also obtain information from the VSP website, www.vsp.com.

	VSP Network	*Non-Network*
Eye Exam		
Every 12 Months*	$10 Co-payment	Up to $40 Benefit
Materials		
Lenses Every 12 Months*	$25 Co-payment	Not Applicable
Single Vision[1]	No Charge	Up to $40
Bifocals[1]	No Charge	Up to $60
Trifocals[1]	No Charge	Up to $60
UV Coating[1]	No Charge	No Additional Benefit
Frames		
Every 24 Months*	Covered up to $105 Allowance[2]	Up to $40
Contacts		
Every 12 Months*	Covered up to $100 Allowance[3]	Up to $100

* Based on your last date of service.

1 Lens options, which can enhance the appearance, durability and function of your glasses, are available to you at VSP's member preferred pricing.

2 If you choose a frame valued at more than your allowance, you'll save 20% on you out-of-pocket cost for frames.

3 Your allowance applies to the cost of your contact lens exam and your contact lenses. You'll receive a 15% discount off the cost of your contact lens exam from a VSP doctor. Your contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts.

Dual Coverage Vision Plan

As with the medical and dental plans, you have the option to elect the Dual Coverage Vision plan if you have primary vision coverage under another vision plan. This plan is also offered by VSP.

Eye Exam	Plan Pays
Every 12 Months*	Up to $10 Benefit
Materials	
Lenses of Frames	Up to $75 per year

* Based on your last date of service.

Life Insurance Benefits

Life insurance benefits are underwritten by Aetna Life Insurance Company. This is a summary of the plan benefits. For complete information and provisions, please refer to your certificate provided by Aetna, contact Aetna Customer Service at 1-866-227-9954 or visit their website, www.aetna.com.

Submit claims to: Aetna Inc. Life Service Center
151 Farmington Avenue – RE52
Hartford, CT 06156-3007
Fax Number for Claim Submission: 1-800-238-6239

In the event of your death, the life insurance company will pay your beneficiary the applicable amount of life insurance benefits as shown below:

Classification	Benefit Amount
Under age 65	$26,000
Age 65 through 69	$16,900
Age 70 through 74	$11,700
Age 75 through 79	$7,800
Age 80 and over	$5,200

The death benefit amount will be reduced by any amount previously paid under the Accelerated Death Benefit provision, described below.

Designation of Beneficiary Form

This booklet contains a Designation of Beneficiary Form and instructions for completing the form. You need only complete the form if you are enrolling for the first time or changing your designation.

Classification Change Date

Any change in your life insurance classification will become effective on the date of your 65th, 70th, 75th, and 80th birthday, or your retirement from active employment.

Accelerated Death Benefit

If, while covered under this life insurance plan you become terminally ill, you may request that the life insurance company pay an Accelerated Death Benefit. Your physician must certify that you suffer from a terminal illness and have a life expectancy of 12 months or less. Upon approval of your request, the insurance company will pay up to 75% of your life insurance benefits, with a minimum payment of $5,000. A nominal amount of interest is charged for the accelerated payment, as defined in your life insurance certificate. The Accelerated Death Benefit payment will be reduced by an interest discount to account for the early payment.

Life Insurance Conversion

If your life insurance ceases because of termination of employment or is reduced due to age, you may convert to an individual policy. You must apply within 31 days of the following events:

- Your insurance ends because you are no longer eligible, you may convert to an amount of life insurance equal to the amount of insurance you had prior to your termination.
- When you reach age 65, 70, 75, and 80 as an active employee and at retirement, you may convert to the amount being reduced.

If you die within the 31-day conversion period, and before the individual policy goes into effect, the amount payable is the maximum amount you could have converted. This amount applies even if you had not applied for or paid the first premium on the individual policy.

Instructions to Complete the Designation of Beneficiary Form

You only need to complete this form if you are enrolling for the first time or if you wish to change your beneficiary designation. You may contact Aetna at 1-800-523-5065 to find out your current designation.

Life insurance benefits are described later in this booklet. If you do not wish to have life insurance coverage please contact the EUTF at 808-586-7390 or toll free at 1-800-295-0089 to request a form to waive your coverage.

Please use only black ink to complete the form.

If you make a mistake in completing the form, line out the erroneous information, add the correct information and initial the correction. The printed material on the form should not be deleted or altered in any way.

In all cases, the relationship of the beneficiary and the beneficiary's social security number should be included with the beneficiary designations.

If a beneficiary is to be contingent, be sure to check the appropriate box. A Contingent Beneficiary will receive benefits only if the Primary Beneficiary(ies) does not survive the insured. If naming more than one Contingent Beneficiary at 100% each, please indicate 1st contingent, 2nd contingent, 3rd contingent, etc.

If a married woman is named beneficiary, her full legal name should be shown. For example: Mary J. Smith, not Mrs. John J. Smith. Likewise, if this form is to be signed by a married woman, she should sign her full legal name.

If a minor child is named beneficiary, the date of birth along with the child's social security number must be given.

Conditions – When you sign the form you are agreeing to these conditions:

Unless otherwise expressly provided in this Designation of Beneficiary form, if any named beneficiary predeceases you, the life proceeds shall be payable equally to the remaining named beneficiary or beneficiaries. If no named beneficiary survives you, any sum becoming payable under said Group Policy(ies) by reason of your death shall be payable as prescribed in said Group Policy(ies).

If this Designation of Beneficiary provides for payment to a trustee under a trust agreement, Aetna Life Insurance Company shall not be obliged to inquire into the terms of the trust agreement and shall not be chargeable with knowledge of the terms thereof. Payment to and receipt by the trustee shall fully discharge all liability of said Insurance Company to the extent of such payment.

If you live in one of the following community property states - Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin - your spouse may have a legal claim for a portion of the life insurance benefit under state law. If you name someone other than your spouse as beneficiary, payment of the death benefit may be delayed until your spouse's claim is resolved. If you make the beneficiary someone other than your spouse, it may be a good idea to complete the spousal consent section, which allows the spouse to waive his or her rights to any community property interest in the benefit. **This is not required if you live in Hawaii.**

When two or more beneficiaries are named, and they are not to share the benefits equally, enter the percentage each beneficiary is to receive on the form in the space provided. Dollars and cents should not be specified. When added together, the sum of the percentages going to the two or more named beneficiaries must total 100%.

If a trustee is named beneficiary, show the exact name of the trust, date of the trust agreement, and the name and address of the trustee.

For example: The John J. Smith Revocable Life Insurance Trust, dated January 1, 1994. John Smith, Trustee, 123 Apple Lane, Hartford, CT 06006.

Aetna Life Insurance Company
Designation of Beneficiary

Please keep a copy for your records.

Group Policyholder Name	**Group Policy Number**
Hawaii Employer-Union Health Benefits Trust Fund	**881930**
Employee/Retiree Name and Address	**Employee/Retiree Social Security Number**

Subject to the terms of the above numbered Group Policy(ies), I request that any sum becoming payable by reason of my death be payable to the following beneficiary(ies). It is my understanding that this designation shall operate so as to revoke all designations of beneficiary and all elections of optional methods of settlement previously made by me under said Policy(ies). If this Designation of Beneficiary refers only to a Group Life Insurance Policy and if I am also insured for Supplemental and/or Group Accidental Death coverage, this designation shall apply to those coverages. This Designation of Beneficiary is subject to all "Conditions" shown in the instructions located in the reference guide.

Employee/Retiree Signature		Date	
Beneficiary Name and Address ☒ **Primary Beneficiary***			
Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
Beneficiary Name and Address (Please check one) ☐ **Primary Beneficiary*** or ☐ **Contingent Beneficiary****			
Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
Beneficiary Name and Address (Please check one) ☐ **Primary Beneficiary*** or ☐ **Contingent Beneficiary****			
Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage
Beneficiary Name and Address (Please check one) ☐ **Primary Beneficiary*** or ☐ **Contingent Beneficiary****			
Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

*If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated above.
**Contingent Beneficiary(ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. If you are naming more than one Contingent Beneficiary at 100% each, please indicate 1st contingent, 2nd contingent, 3rd contingent, etc. in the order of precedence.

SPOUSAL CONSENT FOR COMMUNITY PROPERTY STATES ONLY (Not required in Hawaii) - See Conditions in the reference guide. *** Please note that an employee/retiree is under no obligation to complete the Spousal Consent section below.

I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse Signature ______________________________ Date ______________

Long-Term Care Plan

The long-term care insurance plan is underwritten by Hartford Life Insurance Company. Long-term care includes a wide range of supportive, medical, personal and social services for people who need assistance for an extended period of time. The purpose of Long-Term Care is to maintain and/or increase independence by promoting functionality and the ability to care for oneself. Long-Term Care needs may arise at any time due to an injury, illness or the effects of the natural aging process. Services for Long-Term Care can be provided in your home, by your community, a nursing home, an assisted living facility or an alternate care facility.

Long-Term Care insurance is an affordable way to protect against the risk of losing your savings to pay for Long-Term Care services. Most unplanned Long-Term Care costs are paid directly by individuals and their families. This can mean tapping into hard-earned savings or limiting the income available to support a healthy spouse.

The average cost of one year in a nursing home is over $46,000.[1] Since the average nursing home stay is 2.6 years[2], nursing home costs can exceed $100,000[3]. This is expected to rise at an average annual rate of 3% above the overall rate of inflation. If this trend continues, the annual cost of a nursing home stay will increase from $46,000 to $69,000 by 2015. Without Long-Term Care protection you may lose everything you've worked a lifetime to save.

The following persons, ages 20 through 85 are eligible to enroll in the program on a voluntary, self-pay basis:

1. State and County employees (employed for three months and at least a 50% full-time position) and retirees, as well as
    A. Their spouses
    B. Their parents and parents-in-law
    C. Their grandparents and grandparents-in-law
2. The surviving spouses of deceased retirees or employees killed in the performance of duty
3. The domestic partners of State and County employees and retirees.

There is no automatic enrollment for this coverage. ***You must file a separate enrollment application and pay monthly premiums directly to Hartford Life Insurance Company***. Newly hired employees will be offered a 90-day enrollment period as well.

To receive the necessary enrollment materials, please call (808) 524-1372 (neighbor islands may call toll-free 1-866-299-1234) or FAX your request to 1-888-565-1560. Be sure to include your name, address, city, state, zip, phone number and active or retiree designation.

You may also visit http://www.healthfundltc.com to email a request for enrollment materials.

[1] Health Insurance Association of America, 1999
[2] New England Journal of Medicine, 1991

Hartford Life

Plan Information at a Glance

Total Coverage	The Applicant chooses either a three-year plan or a five-year plan.
Daily Benefit Amounts	The Applicant chooses one of the daily benefit amounts: ▸ $100 per day for Nursing Home Care; $75 per day for Assisted Living Facility Care and Residential Care Homes; and $50 per day for Home Care; or ▸ $150 per day for Nursing Home Care; $112.50 per day for Assisted Living Facility Care and Residential Care Homes; and $75 per day for Home Care; or ▸ $200 per day for Nursing Home Care; $150 per day for Assisted Living Facility Care and Residential Care Homes; and $100 per day for Home Care. Note: According to Hartford, a semi-private room in a nursing home in Hawaii averages $181 per day.
Available Coverage	Comprehensive includes: Nursing Home Care, Home Health Care, Adult Day Care, Respite Care, Assisted Living Facilities, Residential Care Homes and Supportive Services.
Deductible Period	Ninety (90) calendar days once per lifetime.
Return of Premium Upon Death Benefit	If death occurs at age 65 or earlier, 100% of premiums are returned, less any benefits paid. The amount of premium decreases by 10% each year after age 65, with no premium returned if death occurs at age 75 or later. **The applicant may decline this benefit at the time of application.**
Nonforfeiture Benefit	This benefit provides for continuation of your coverage on a limited basis if you elect to voluntarily terminate coverage after paying premiums for at least 36 months. **The applicant may decline this benefit at the time of application.**
Inflation Protection Option	Periodic Benefit Increases – at least every 3 years you will be offered an option to increase coverage for an additional premium amount; this option is automatically included in the Health Fund program. Automatic Inflation Protection – built-in 5% compounded annual increases in coverage with level premiums; the applicant may accept or decline this option at the time of application.
Advisory Services	Available to help develop a plan of care and to identify quality providers.
Benefit Eligibility	Loss in 2 out of 6 Activities of Daily Living or severe cognitive impairment.
Portability	Coverage is fully portable to anywhere in the United States.
Rates	Rates are based on your age when your application is received. They are designed to remain level over your lifetime and can only be changed on a class basis not because of an individual's age or illness.
Guaranteed Renewable	Your coverage can never be canceled as long as you continue to pay your premiums when due.

Important Notices

Many federal and state laws guide the administration of all health benefits insurance plans. While official insurance contracts actually govern your rights and benefits under each plan in which you are enrolled, the following information is provided to help you understand your statutory rights and benefits. If any discrepancy exists between the information provided in this section and your official insurance documents, the official insurance documents will prevail.

If you have any questions about this section, please call the Hawaii Employer-Union Health Benefits Trust Fund (the EUTF) at 808-586-7390.

Women's Health & Cancer Rights Act

Your health insurance plan is required by the Women's Health and Cancer Rights Act of 1998 to provide benefits for mastectomy-related services, including:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Your plan will provide coverage in consultation with the attending physician and patient.

Coverage for breast reconstruction and related services will be subject to deductibles, co-payments, and coinsurance amounts that are consistent with those that apply to other benefits under the Plan. If you have any questions about the Women's Health and Cancer Rights Act, please call your insurance carrier or the EUTF at 808-586-7390.

Newborns' & Mothers' Health Protection Act

Generally, group health plans and health insurance issuers who offer group insurance coverage may not (under federal law) restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to:

- Less than 48 hours following a normal vaginal delivery, or
- Less than 96 hours following a caesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a hospital stay not in excess of 48 hours (or 96 hours). However, the Plan may still require pre-certification of any hospital admission in connection with childbirth, in order for you to obtain the maximum level of benefits available under the Plan.

Qualified Medical Child Support Order

Your health insurance plan honors qualified medical child support orders (QMCSOs). This means that if a QMCSO issued in a divorce or legal separation proceeding requires you to provide medical coverage to a child who is not in your custody, you may do so under the Plan. To be qualified, a medical child support order must include:

- Name and last known address of the parent who is covered under the health insurance plan,
- Name and last known address of each child to be covered under the health insurance plan,
- Type of coverage to be provided to each child, and
- Period of time coverage will be provided.

Send QMCSOs to the EUTF, which is your Plan Administrator. Upon receipt, the EUTF will notify you and give you the procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the Plan.

National Medical Support Notices

The EUTF (your health benefits plan administrator) also honors qualified National Medical Support Notices (NMSNs). These Notices are similar to a QMCSO, but are issued by a state agency pursuant to a medical child support order. Upon receipt of the NMSN, the Employer will, within 40 business days, return the Notice to the state agency if the specified coverage is not available for one of the reasons set forth on the Notice, or forward the Notice to the EUTF, the Plan Administrator, if the specified coverage is available.

If the Employer forwards the Notice to the EUTF, the EUTF will, within 40 business days, return the Notice to the state agency and/or the parties concerned to inform them whether the Notice constitutes a QMCSO.

If the Notice qualifies, the EUTF will notify the state agency either that the child(ren) is/are currently enrolled

or will be enrolled in the coverage available under the EUTF.

If you are not enrolled and there is more than one coverage option available, the EUTF will inform the state agency of the coverage options from which you may elect coverage. In this event, the EUTF will also notify your employer, who will determine whether federal or state withholding rules permit withholding from your salary or wages the amount required to provide coverage to the child(ren) under the terms of the health insurance plan, and, if so, to withhold the required amounts from your pay for such coverage and remit these amounts withheld to the EUTF.

If the Notice is not qualified, then within 40 business days, the EUTF will notify the state agency and the parties involved, the specific reason(s) why the Notice failed to qualify. The EUTF may also provide additional notifications as provided for in the NMSN's instructions.

Continuation of Group Health Coverage Under COBRA: Initial Notice

A federal law, commonly known as "COBRA," requires most employers to offer employees and their covered dependents the opportunity to elect a temporary continuation of health coverage, at group rates, when coverage would otherwise be terminated, because of a "qualifying event" (listed below).

The section serves as your initial notice of your rights and obligations under COBRA. It is subject to change without warning, as interpretations or changes in the law do occur. Please read this notice carefully, share it with your family, and keep it in your file.

Qualifying Events

Employees

If you are an employee covered under a group health plan, you (and your covered dependents) may elect COBRA coverage if you lose your group health coverage due to either of these "qualifying events":

- Termination of your employment (for reasons other than gross misconduct), or
- Reduction in your work hours causing you to be ineligible for health benefits insurance.

Covered Spouses

If you are the covered spouse of an employee enrolled in a group health plan, you may elect COBRA coverage if you lose group health coverage due to any of these "qualifying events":

- Termination of your spouse's employment (for reasons other than gross misconduct), or reduction in your spouse's work hours causing him or her to be ineligible for Plan benefits,
- Death of your spouse,
- Divorce or legal separation from your spouse, or
- Employee-beneficiary becomes entitled to Medicare benefits.

Covered Children

Dependent children who are covered under a group health plan have the right to elect COBRA coverage if they lose coverage under the Plan due to any of these "qualifying events":

- The employee-parent's employment stops (for reasons other than gross misconduct), or work hours are reduced resulting in ineligibility for Plan benefits,
- Death of the employee-parent,
- Parents' divorce or legal separation,
- Employee-parent becomes entitled to Medicare benefits, or
- Dependent child ceases to be a "dependent child" under the health insurance plan.

Obtaining COBRA Coverage

If your employment terminates, the EUTF will automatically send you a COBRA continuation notice. However, if you get divorced or legally separated, or if your dependent child no longer meets the eligibility requirements under the Plan, you or your dependents must notify the Plan Administrator and request COBRA coverage. You must make this request within 60 days of the qualifying event. If you fail to give this notice within the 60-day period, your spouse and any covered dependent that loses coverage will NOT be offered COBRA coverage. Also, if you fail to give this notice and your insurance carrier mistakenly pays claims for expenses incurred after the date your coverage is supposed to end because of one of these qualifying events, then you, your spouse or your covered children will have to reimburse your insurance carrier for any claims so paid.

You will have 60 days from the date the EUTF provides you opportunity to enroll through COBRA, to make a decision about your COBRA options. If you, your spouse, or dependents do not choose COBRA coverage within this 60-day period, you will lose the right to elect COBRA coverage completely.

A covered employee or the spouse of the covered employee may elect continuation coverage for all family members. However, each covered person has an independent right to elect COBRA coverage. A covered spouse or covered dependent child may elect

continuation coverage even if the covered employee does not.

You do not have to show that you are insurable to choose continuation coverage. However, COBRA coverage is provided subject to the individual's eligibility for coverage. Your Employer reserves the right to terminate COBRA coverage retroactively if someone is determined to be ineligible for coverage under the Plan.

Adding New Dependents After Coverage Begins

If you have already elected COBRA, and you have a life event, such as marriage, birth, adoption, placement for adoption, or you have declared a domestic partner, or, if an eligible dependent declines coverage under the Plan because of other coverage and later loses such other coverage due to certain qualifying events — you may add your new spouse/domestic partner, newborn children and adopted children, or the previously covered dependent(s) to your COBRA coverage within 30 days of the event.

Cost of Coverage

Insurance carriers providing coverage for the EUTF beneficiaries will administer the billing and collection of COBRA premiums.

You will be charged the full premium under the group health plan for COBRA coverage, plus a 2% administrative charge. If you are disabled and you extend your coverage for more than 18 months, you will have to pay the full cost of coverage plus another 50% of the premium for months 19 through 29.

You may pay for COBRA coverage on a monthly basis. Your first payment will cover the period from the date your former coverage terminated to the date you elect COBRA coverage — and is due within 45 days of your COBRA election date. The EUTF will give you specific cost information at that time. For subsequent premium payments, you have a grace period of 30 days for payment of the regularly scheduled premium. If you fail to pay the full monthly premium amount when due, your COBRA coverage will be terminated for non-payment. If this happens, you will not be allowed to reinstate your COBRA coverage.

Maximum Coverage Periods

Under COBRA, the maximum coverage periods are:

18-Months – For group health coverage lost due to the employee's termination of employment (other than for gross misconduct) or reduction in hours. There are two exceptions:

- **Totally Disabled Individuals**: The 18-month period may be extended to 29 months if an Employee or dependent is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage. This 11-month extension is available to all individuals who are covered under COBRA due to a termination or reduction in hours of employment. To receive this extension, the employee or dependent must notify the Employer or the EUTF within 60 days of the Social Security Administration's total disability determination, and before the end of the initial 18-month period. The affected individual must also notify the EUTF, the Plan Administrator, within 30 days of any final determination that the individual is no longer disabled.
- **Second Qualifying Event Occurs**: If a second qualifying event (such as the employee's death or divorce) occurs during the 18-month or 29-month coverage period, the initial maximum coverage period of 18 months may be extended to 36 months from the date of the initial qualifying event.

36 Months – If you are a spouse or a dependent child and you lose group health coverage because of the employee's death, divorce, legal separation, or the employee's becoming entitled to Medicare benefits, or because you lose your status as a dependent child under the Plan.

Special Rule Regarding Medicare

If you enroll in Medicare before you terminate employment or before you lose full-time status, your covered spouse and dependents may continue COBRA coverage for 36 months from the date the employee became entitled to Medicare.

When Coverage Ends

Your COBRA coverage will terminate automatically before the maximum coverage period ends, when any of the following events occur:

- Your Employer no longer provides group health coverage to any of its employees.
- Payment of any required COBRA premium is not received within 30 days of its due date.
- After electing COBRA, you become covered under another group health plan (as an employee or a dependent), which does not contain any exclusion or limitation with respect to any pre-existing condition you have.
- After electing COBRA, you or your dependents become entitled to (enrolled in) Medicare.
- You became entitled to a 29-month maximum coverage period, but then the Social Security

Administration determines that you or your dependents are no longer disabled.

Once COBRA coverage is cancelled, it will not be reinstated.

Rights and Benefits

COBRA participants in a health insurance plan have the same rights and benefits as active participants in the plan. Any changes made to the plan for active participants will also apply to COBRA participants.

HIPAA Initial Notice: Notice of Privacy Rules

Effective date of this notice is March 1, 2004.

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

A federal law, commonly known as HIPAA (the Health Insurance Portability and Accountability Act of 1996), governs all group health plans' use and disclosure of medical information. You may find HIPAA's privacy rules at 45 Code of Federal Regulations Parts 160 and 164.

This notice describes the EUTF's privacy practices and your rights regarding the uses and disclosures of your medical information.

The EUTF acknowledges that your medical and health information is personal – and is committed to protecting your privacy.

For administration purposes, the EUTF has access to a record of your claims reimbursed under your health insurance benefits plan. This notice applies to all of the medical records that the EUTF maintains or can access. Your personal doctor, health care provider, or health insurance carrier might have different policies or notices regarding their use and disclosure of medical information that they maintain or create. However, HIPAA applies to all organizations or persons that maintain personal health information, if they fall under HIPAA's definition of "Covered Entities."

By law, the EUTF MUST:

- Make sure that medical information that identifies you is kept private,
- Give you this notice of the EUTF's legal duties and privacy practices with respect to your medical information,
- Retain copies of the notices the EUTF issues to you,
- Retain any written acknowledgments that you received the notices, or document the EUTF's good faith efforts to obtain such written acknowledgments from you, and
- Follow the terms of the notice that is currently in effect.

HIPAA also requires the EUTF to tell you about:

- The EUTF's uses and disclosures of your medical information,
- Your privacy rights with respect to your medical information,
- Your right to file a complaint with the EUTF and with the Secretary of the Department of Health and Human Services, and
- The person or office at the EUTF whom you may contact for additional information about the EUTF's privacy practices.

How the EUTF May Use and Disclose Your Medical Information

The following categories describe the different ways the EUTF may use and disclose your medical information. Some uses and disclosures of your medical information require your authorization or the opportunity to agree or object to the use or disclosure. Other uses and disclosures do not. This notice clearly identifies whether or not the use or disclosure of your medical information requires your authorization or the opportunity to agree or object. Each category contains an explanation of what is meant by the "use and disclosure" of your medical information, and some examples. Not every use or disclosure in a category will be listed. However, all of the ways the EUTF is allowed to use and disclose your medical information will fall into one of the categories listed.

The following categories DO NOT REQUIRE the EUTF to obtain your consent, authorization, or to provide you the opportunity to agree or object to the use or disclosure.

For Treatment: the EUTF may use or disclose your medical information to help you get medical treatment or services through the EUTF. The EUTF may disclose your medical information to health care providers, including doctors, nurses, technicians, medical students, or other health care professionals who are providing you with services covered under the your insurance plan. For example, the EUTF might disclose the name of your child's dentist to your child's orthodontist so that the orthodontist may ask the dentist for your child's dental X-rays.

For Payment: the EUTF may use and disclose your medical information in the process of determining your eligibility for benefits under the EUTF, to facilitate

payment to health care providers for the treatment or services you have received from them, to determine benefit responsibility under the EUTF, and to facilitate reviews for medical necessity/appropriateness of your care. For example, the EUTF may tell your doctor whether you are eligible for coverage under the EUTF, or what percentage of the bill may be paid by the EUTF. Likewise, the EUTF may share your medical information with another entity to assist with the adjudication or subrogation of your claims or to another health plan to coordinate benefit payments.

For EUTF Operations: the EUTF may use and disclose your medical information for health care operations and other EUTF operations. These uses and disclosures are necessary to administer the EUTF benefit plans. For example, the EUTF may use and disclose your medical information to conduct or facilitate quality assessments, improvement activities, performance and compliance reviews, auditing, fraud and abuse detection, underwriting, premium rating and other activities related to creating, renewing or replacing insurance contracts or benefit plans, claims review and appeals, legal functions and services, business planning and development, and other activities related to business management and administration. In connection with the foregoing, the EUTF may disclose your medical information to third parties who perform various health care operations or EUTF operations on its behalf.

As Required By Law: the EUTF will disclose your medical information when required to do so by federal, state or local law. For example, the EUTF may disclose your medical information when required to do so by a court order in a civil proceeding such as a malpractice lawsuit. Or, the Secretary of the Department of Health and Human Services might require the use and disclosure of your medical information to investigate or determine the EUTF's compliance with federal privacy regulations (this notice).

To Avert a Serious Threat to Health or Safety: the EUTF may use and disclose your medical information when necessary to prevent a serious threat to your health or safety, or to the health and safety of the public or another person. However, any such disclosure would be made only to a person able to help prevent the threat. For example, the EUTF may disclose your medical information in a legal proceeding regarding the licensure of a doctor.

Special Situations

Disclosure to Business Associates: the EUTF may disclose your medical information to business associates in carrying out treatment, payment, health care operations and EUTF operations. For example, the EUTF may disclose your medical information to a utilization management organization to review the appropriateness of a proposed treatment under your insurance plan.

Disclosure to Health Insurance Companies or Health Maintenance Organizations: In carrying out treatment, payment or health care operations, the EUTF may disclose your medical information to health insurance companies or health maintenance organizations (HMOs) that it contracts with to provide services or benefits under its health benefits plans. For example, the EUTF may disclose your medical information to the Hawaii Medical Service Association, Kaiser Permanente and Kaiser Health Plan, Hawaii Dental Service, Vision Service Plans, ChiroPlan Hawaii or Royal State Insurance in order to verify your eligibility for benefits or services.

Disclosure to the Plan Sponsor and Its Representatives: the EUTF is sponsored by State, county and other public employers who are represented on the EUTF's Board of Trustees. The EUTF may disclose information to the EUTF's Board of Trustees, the sponsoring public employers, and the Employees Retirement System (ERS) for payment, health care operations, and EUTF operations. For example, the EUTF may disclose information to the sponsoring employers about whether you are participating in a group health plan that is offered by the EUTF, or whether you are enrolled or disenrolled in any such group health plan. Disclosure to the sponsoring employers may include disclosures to your departmental personnel officer (DPO) or any other person who functions as your employer's personnel officer. In the event you appeal a denied claim or other matter to the EUTF's Board of Trustees, the EUTF may disclose your medical information to the EUTF's Board of Trustees and its staff, consultant, and legal counsel as may be necessary to allow the EUTF's Board of Trustees to make a decision on your appeal. The EUTF may also disclose your medical information to the EUTF's Board of Trustees for plan administration functions, including such functions as quality assurance and auditing or monitoring the operations of group health plans that are part of the EUTF.

Public Health Activities: the EUTF may disclose your medical information to a public health authority for the purpose of preventing or controlling disease, injury or disability or to report child abuse or neglect.

Organ and Tissue Donation: If you are an organ donor, the EUTF may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, the EUTF may release your medical information as required by military command authorities. The EUTF may also release medical information about

foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: the EUTF may release your medical information for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Health Oversight Activities: the EUTF may disclose your medical information to a health oversight agency for activities authorized by law. These oversight activities can include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, the EUTF may disclose your medical information in response to a court order or administrative ruling. The EUTF may also disclose your medical information in response to a subpoena, discovery request, or other lawful process by someone involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the medical information requested.

Law Enforcement: the EUTF may release your medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process,
- To identify or locate a suspect, fugitive, material witness or missing person,
- About the victim of a crime if, under certain limited circumstances, the EUTF is able to obtain the person's agreement,
- About a death the EUTF believes might be the result of criminal conduct, and
- In emergency circumstances to report a crime, the location of a crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: the EUTF may release your medical information to a coroner or medical examiner. This might be necessary, for example, to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities: the EUTF may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

The following category REQUIRES the EUTF to obtain your written authorization for the use or disclosure.

Psychotherapy Notes: Generally the EUTF must obtain your written authorization to use and disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. However, the EUTF may use and disclose your psychotherapy notes when needed by the EUTF to defend against a lawsuit filed by you.

The following category REQUIRES that the EUTF gives you an opportunity to agree or disagree prior to the use or disclosure.

Family or Friends Involvement: the EUTF may disclose your medical information to family members, other relatives, or your friends if:

- The medical information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given the opportunity to object to the disclosure and have not objected.

Your Rights Regarding Your Medical Information

You have the following rights regarding your medical information maintained by the EUTF:

Right to Inspect and Copy Your Medical Information: You have the right to inspect and obtain a copy of your medical information contained in a "designated record set," for as long as the EUTF maintains your medical information. The designated record set includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the EUTF to make decisions about people covered under the EUTF's health benefits plans. Information used for quality control or peer review analyses and not used to make decisions about people covered by the EUTF health benefits plans is not contained in the designated record set.

If you request a copy of your medical information, it will be provided to you in accordance with the time limits required under Part II of Chapter 92F, Hawaii Revised Statutes, and the rules enacted thereunder. Under those laws, the EUTF will generally provide a copy of your medical information to you within ten (10) business or working days. However, in certain circumstances, the EUTF may be entitled to additional time to respond to your request.

You or your personal representative must complete a form to request access to your medical information contained in the designated record set. You must submit

the completed request form to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice.

If you request a copy of the information, the EUTF may charge a fee for the costs of copying and mailing the information to you or for other supplies associated with complying with your request.

The EUTF may deny your request to inspect and copy medical information in certain, very limited circumstances. If you are denied access to medical information, you may appeal.

If the EUTF denies your request to inspect or copy your medical information, the EUTF will provide you or your personal representative with a written denial identifying the reason(s) for the denial. The denial will also include a description of how you may exercise your appeal rights, and a description of how you may file a complaint with the Secretary of the Department of Health and Human Services.

Right to Amend Your Medical Information: If you think that your medical information is incorrect or incomplete, you may ask the EUTF to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the EUTF.

To request an amendment, you must submit your request, in writing, to the EUTF Privacy Officer. Your written request must include a reason that supports your request.

After you request that the EUTF amend your medical information, the EUTF must comply with your request within twenty (20) business or working days, or notify you that your request has been denied.

The EUTF may deny your request for an amendment to your medical information if your request is not in writing or does not include a reason to support the request. In addition, the EUTF may deny your request if you ask the EUTF to amend information that:

- Is not part of the medical information kept by or for the EUTF,
- Was not created by the EUTF, unless the person or entity that created the information is no longer available to make the amendment,
- Is not part of the information which you would be permitted to inspect and copy, or
- Is accurate and complete.

If the EUTF denies your request in the whole or in part, the EUTF must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial, and have that statement included with any future disclosure of your medical information.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" if a disclosure was made without your authorization for any purpose other than treatment, payment, or health care operations, or where the disclosure was to you about your own medical information.

To request this list of disclosures, you must submit a written request to the EUTF Privacy Officer. Your request must state a time period for which you are requesting the list of disclosures. This period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within any 12-month period will be provided free of charge. For additional lists, the EUTF may charge you for the costs of providing the list. The EUTF will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before you incur any costs.

The EUTF has 60 days from the date it receives your request to provide you the list of disclosures, and is allowed an additional 30 days to comply, if it provides you with a written statement of the reasons for the delay and the date by which the accounting will be provided.

Right to Request Restrictions: You have the right to request a restriction or limitation on your medical information uses or disclosures for treatment, payment or health care operations. You also have the right to request a limit on your medical information that the EUTF discloses to someone involved in your care or payment for your care, like a family member or friend. For example, you could ask that the EUTF not use or disclose information about a surgical procedure you had.

The EUTF is not required by law to agree to your request.

You or your personal representative must complete a form to request restrictions on the use or disclosure of your medical information. You must submit the completed form to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice.

In your request, you must indicate:

- What information you want to limit,
- Whether you want to limit the EUTF's use, disclosure, or both, and
- To whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that the EUTF communicate with you about your medical information or other medical

matters in a certain way, or at a certain location. For example, you may ask that the EUTF contact you only at work or by mail.

To request confidential communications, you must submit a written request to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice. The EUTF will not ask you the reason for your request and will accommodate all reasonable requests. Your request must specify how and/or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to receive a paper copy of this notice. You may ask the EUTF to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to request a paper copy of this notice.

To obtain a paper copy of this notice, submit a written request to the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice.

A Note about Personal Representatives

You may exercise your privacy rights through a personal representative. Your personal representative will be required to provide evidence of his or her authority to act on your behalf before that person will be given access to your medical information or allowed to take any action on your behalf with respect to your medical information. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public,
- A court order appointing the person as the your conservator or guardian, or
- An individual who is the parent of a minor child.

The EUTF may decide to deny a personal representative access to medical information of a person if it thinks this will protect the person represented from abuse or neglect. This also applies to personal representatives of minors.

However, state or other applicable law will govern whether the EUTF is permitted to disclose an unemancipated minor dependent child's medical information to the child's parent(s). State or other applicable law will also govern whether the EUTF is permitted to provide a parent's access to his or her child's medical information.

Changes to This Notice

The EUTF reserves the right to change this notice. The EUTF also reserves the right to make the revised or changed notice effective for medical information it already maintains, or has access to about you — as well as any information the EUTF receives in the future. The EUTF will post a copy of the current notice on the EUTF's web site. This notice will contain the effective date of the current notice on the first page, in the top right-hand corner.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, your rights, the duties of the EUTF or other privacy practices stated in this notice.

Minimum Necessary Standard

When the EUTF uses or discloses your medical information, or requests your medical information from another entity, the EUTF will make reasonable efforts not to use, disclose or request more than the minimum amount of your medical information needed to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply to:

- Disclosures to or requests by a health care provider for treatment,
- Uses by you or disclosures to you of your own medical information,
- Disclosures made to the Secretary of the Department of Health and Human Services,
- Uses or disclosures that may be required by law,
- Uses or disclosures that are required by the EUTF's compliance with legal regulations, and
- Uses and disclosures for which the EUTF has obtained your authorization.

This notice does not apply to medical information that has been "de-identified." De-identified information is medical information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

In addition, the EUTF may use or disclose "summary health information" to obtain premium bids or to modify, amend or terminate the EUTF's health benefits plans. Summary health information is information that summarizes the claims history, claims expenses, or types of claims experienced by individuals for whom the EUTF has provided benefits, and from which identifying information has been deleted in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice.

You may also file a complaint with the Secretary of the Department of Health and Human Services at:

Secretary, DHHS
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

You must submit any complaints in writing. The EUTF will not penalize or retaliate against you for filing a complaint.

Other Uses and Disclosures of Your Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to the EUTF will be made only with your written authorization. If you provide the EUTF with authorization to use or disclose your medical information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the EUTF will no longer use or disclose your medical information for the reasons covered by your written authorization. You should understand that the EUTF is unable to take back any disclosures that have already been made with your authorization, and that the EUTF is required to retain any records regarding any care or services provided to you.

Questions?

If you have any questions about this notice, please contact the EUTF Privacy Officer, whose address is rovided at the end of this HIPAA notice.

Governing Law

If there is any discrepancy between the information in this notice and the actual HIPAA regulations, the regulations will prevail, and the EUTF will use and disclose your medical information in a manner consistent with the regulations.

You may contact the EUTF Privacy Officer at the following address:

The EUTF Privacy Officer
P.O. Box 2121
Honolulu, HI 96805-2121
Tel: (808) 586-7390
Toll Free: 1-800-295-0089
Fax: (808) 586-2161
Email: eutf@hawaii.gov

Notes

Notes

EUTF
P.O. Box 2121
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